



IN THE ABSTRACT

A quarterly newsletter from the Kentucky Cancer Registry

Large Hospital Edition

April 2002

QA CORNER:

As you know, text documentation is a mandatory field and serves to help you, the hospital based registrar, as well as the Kentucky Cancer Registry. We frequently use text to reconcile case discrepancies. Recently, SEER added new EOD codes for breast cancer, and these new codes are available in the 4.51c update of CPDMS. KCR regional coordinators are currently updating your computers with these new codes and will be reviewing them with you. In addition, the regional coordinators will run a report at your facility and re-code the appropriate breast cases for you.

This gave me an opportunity at KCR to see how well we are doing with text documentation. Congratulations to those of you who are doing a very good job of text documentation. Your charts will not need to be pulled to re-code these cases. Below I will describe the study I conducted and the outcome for your information.

QA STUDY:TEXT

Review text documentation from the central registry in 219 breast cancer cases diagnosed in the year 2000 with EOD codes equal to 10, 20, or 30 and tumor size coded 999.

Reason for study: SEER has added new EOD codes for better staging information when tumor size is coded 999. All 219 cases will need to be reviewed and re-coded at the hospital submitting these cases.

Question to be answered: What percent of these cases can be re-coded from text documentation?

Outcome: 57.5% or 126 cases can be re-coded from text documentation.

Summary:

Text will be helpful in re-coding EOD or Tumor size in 126 cases (57.5%)

Text was not helpful in 66 cases (30.1%)

Text was not documented in 27 cases (12.3%)

Plan: Offer additional training in defensive text documentation.

Reita Pardee, CTR
QA Manager

PEOPLE NEWS



Welcome to New Hires:

- | | |
|-----------------------|---|
| ★ Vivian Wyatt | University of Louisville Hospital, Louisville |
| ★ Gail Henderson, CTR | James Graham Brown Cancer Center, Louisville |
| ★ Rochelle Smith | James Graham Brown Cancer Center, Louisville |

Resignations:

- | | |
|-----------------|--|
| ★ Tamara Wilson | Frankfort Regional Medical Center, Frankfort |
|-----------------|--|

Congratulations!

ACoS Cancer Program Approvals

The following received full 3-year approvals:

- ◆ ARH Regional Medical Center, Hazard
Scottie Cornett, Registrar

- ◆ U of L/James Graham Brown Cancer Center, Louisville
Sam Underwood & Mary Wilson, CTRs
Michele Weaver & Martina Ward Wilson, Registrars

GOLDEN BUG AWARD

And the newest winner of the Golden Bug Award is ---- Donna Warwick, CTR, registrar at Caritas Medical Center in Louisville. Donna discovered that the warning abstractors should encounter when an invasive recurrence was coded on an in-situ case was missing from the software released for 2001 diagnoses. This “bug” has been corrected in version 4.51d. Congratulations, Donna, on being the latest recipient of this highly coveted award!◆



April 2002

NBCR News & Fall 2002 Test Date...

ATTENTION ALL CTRs: The National Board for Certification of Registrars needs your current contact information in order to build their new database. You are requested to visit their

website (www.nbc.org/) and complete an Update Form as soon as possible.

A recent perusal of the NBCR website shows the fall 2002 CTR test date as follows:



Application Deadline

August 8, 2002

Exam Date

September 14, 2002

The cost of the test is \$175 for NCRA members and \$250 for all others. Coding books to be used on the 2002 exam will be the ICD-O-3, SEER Summary Staging Manual 2000, and the AJCC Cancer Staging Manual 5th Edition. You must obtain revised handbooks and application forms for the 2002 examination. To receive an application form for this fall's exam, go to the website and place your order. ♦

Casefinding Applause....

We want to send special thanks to the hospital registrars who routinely send KCR information on cancer cases that are considered to be “nonreportable” by their hospitals. Without your ongoing diligence, our cancer reporting would not be complete! So, stand up and take a bow... We **really** appreciate your hard work.

For those who are unaware of this facet of registry responsibilities, allow us to introduce you to the procedure for handling nonreportables. Whenever a “specimen only” malignant path report or cytology report (patient never entered your hospital; tissue sent to your lab from MD office or outside surgery center) crosses your desk, send a copy of the report and a copy of the face sheet, if available, to KCR. Our non-

hospital facility abstractors will abstract and enter the case into CPDMS.

Another example of a nonreportable case is shown on page 3 of CPDMS under number 1. “An outpatient CT scan of the chest reads: probable carcinoma of the right lung. The patient does not return to your institution for diagnostic confirmation or treatment. Send these...with face sheet to KCR.” Each hospital registry should maintain a list of these nonreportable cases in an X-accession log for future reference. ♦

CANCER AWARENESS MONTHS

APRIL	Cancer Control Month
MAY	Melanoma/Skin Cancer
JUNE	Prostate Cancer
AUGUST	Melanoma/Skin Cancer

SEER CODING QUESTIONS

Questions submitted to the SEER Inquiry System produced the following answers. These may help clarify some of your own abstracting dilemmas. May this serve as yet another method of continued education.

Question 1: We are finding out that most of the myelodysplastic syndromes that we identify this year have no documented diagnosis date. Must we assume they are reportable this year (2001)? How do we determine what is first course therapy with these diseases? Most have several transfusions over many months. If your hospital gives only the 2nd transfusion 7 months after diagnosis, what course is this?

Answer: Those cases with unknown dates of diagnosis identified before 1/1/2002 would not be accessioned/reportable. The cases with unknown dates of diagnosis found on and after 1/1/2002 would be accessioned/reportable. The first course of treatment for these hematopoietic primaries lasts until there is a treatment change. For the case you cite, the second transfusion (7 months after diagnosis) would be first course treatment.

Question 2: For colon primaries, nodules in pericolic fat are to be considered lymph nodes. What about nodules in mesentery or omentum?

Answer: Do not consider metastatic nodules in the mesentery or metastatic nodules in the omentum as positive regional nodes for staging purposes. For colon primaries, metastatic nodules in the mesentery and omentum would be coded as distant metastasis.

Question 3: How should the date of diagnosis be coded when a nondiagnostic scan is done prior to the biopsy? A 4/25/01 Chest CT shows a RUL mass and mediastinal lymphadenopathy. The 5/14/01 RUL biopsy reveals small cell carcinoma. Is the date of Dx 5/14/01, or is it retroactive to 4/25/01, based on note 7, which defines mediastinal LAD as involvement?

Answer: The term "lymphadenopathy" does indicate involvement for lung cancer cases, but it is not one of the terms used for diagnosis. Code the date of diagnosis as May 2001.

Question 4: For NHL, how do you code the 6th digit grade field when the phenotype is combined B cell and T cell?

Answer: Code as 9, unknown. There is no combination code for combined B cell and T cell. There is no hierarchy established for choosing one code over the other, so coding as a pure B cell or a pure T cell would misrepresent the phenotype.

Abstracting reminders ~ ~ ~

- When 'place of birth' information is unknown for a given patient, use code '999' as specified on page 50 of CPDMS. Please DO NOT USE '000' in this field.
- When adding Rituxan into a therapy field, remember that this agent is NOT a type of chemotherapy. Rituxan falls under the Biological Response Modifier/Immunotherapy category, as it is a monoclonal antibody. (SEER 2000 Abstractors and Coders Workshop)
- Herceptin is another Biological Response Modifier/Immunotherapy agent. It is used for metastatic breast cancer when tumors overexpress the HER2 protein. (SEER 2000 Abstractors and Coders Workshop)
- Aredia, known generically as Pamidronate, is an ancillary drug. Because this agent prevents bone resorption in patients with hypercalcemia of multiple myeloma, it is not anti-neoplastic. Do not add it into a treatment field as chemotherapy. (SEER 2000 Abstractors and Coders Workshop)

Calendar of Events

May 22-24, 2002 - NCRA Annual Conference
Opryland Hotel, Nashville TN

June 11-13, 2002 - NAACCR Annual Conference
Westin Harbour Castle Hotel, Toronto, Ontario, Canada

September 5-6, 2002 - KCR Annual Fall Workshop
Hilton Suites in Lexington Green, Lexington KY

KCR TRAINING



The next Abstractors' Training Class has been rescheduled for **May 7, 8, and 9** at KCR headquarters (2365 Harrodsburg Road, Suite B100, Lex KY) from **8:30am through 4:30pm** each day. Interested parties may call Reita Pardee at 859.219.0773 ext 233.❖

Special Feature: Coding Rules for Inflammatory Breast Cancer

Inflammatory breast cancer is a clinicopathologic entity. In order to classify a case as “inflammatory” the following must be present:

Diffuse dermal lymphatic invasion beyond that directly overlaying the tumor is noted in the pathology report AND

A clinical diagnosis of inflammatory cancer is made by a physician. This clinical diagnosis may be described in such terms as diffuse, brawny induration (hardening), or warmth, redness and edema of the skin. This clinical information will most likely be found in the history and physical exam.

It is important to note that the mention of dermal lymphatic invasion by itself on a pathology report is NOT enough evidence to classify a case as “inflammatory”. Likewise, the clinical characteristics of edema, warmth, redness and brawny induration without dermal lymphatic invasion cannot classify the cancer as “inflammatory”. (See Workbook for Staging of Cancer, 2nd Edition, p. 74, #26 & 27)

If the case meets the above conditions, the following are the correct codes for the data elements listed:

TOPOGRAPHY: Code C50.9 if no mention of a palpable mass; code to site of palpable mass otherwise. (Per SINQ 12/00)

HISTOLOGY: 8530/3

Note:

- 1) If the pathology report reflects multiple histologic diagnoses, i.e. lobular carcinoma AND inflammatory carcinoma, code to inflammatory provided the previously mentioned clinicopathologic findings are present.**
- 2) If the final pathology diagnosis states only lobular cancer, for example, but dermal lymphatic invasion is noted in the microscopic assessment AND the clinical characteristics of inflammatory cancer are present, code to inflammatory cancer.**
- 3) Dermal lymphatic invasion is noted in the path report AND the path report also gives a diagnosis of inflammatory cancer.**

TUMOR SIZE: 998 (from EOD coding manual)

SEER EOD EXTENT: 70

TNM: pT4d

SOURCES:

- 1) AJCC Cancer Staging Manual, 5th Edition, P. 171-174**
- 2) Workbook for Staging of Cancer, 2nd Edition, P. 74**
- 3) ACoS Inquiry and Response System, 12/28/99**
- 4) Conversations with April Fritz, Data Quality Manager, SEER Program (3/2000)**